

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 18, 2017

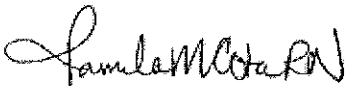
Ms. Barbara Buskey, Manager
Vergennes Residential Care Home
34 North Street
Vergennes, VT 05491-1108

Dear Ms. Buskey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 7, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0311	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/07/2017
NAME OF PROVIDER OR SUPPLIER VERGENNES RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 34 NORTH STREET VERGENNES, VT 05491		
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R128	Continued From page 1 mg. PO Q 4 HR PRN pain". b. Resident #2 had orders for Trazadone 50 mg. tablet, 1 tab by mouth at bedtime as needed dated 11/21/16. These orders were written by the psychiatrist. Per review, the September 2017 MARs stated "Trazadone 50 mg., 1 - 2 tabs PO HS (hour of sleep) PRN". The resident's primary care provider signed orders on 2/21/17 for the dose range of 1 - 2 tabs. Per review of the monthly psychiatrist note for January, 2017, s/he wrote "Trazadone 50 MG at HS unchanged." During interview with the facility RN, s/he was not aware of the discrepancy in the 2 orders from 2 different providers and the psychiatrist was not contacted to see if s/he wanted to keep the original orders that s/he had written in place. In addition, the order with the dose range is not an appropriate order without specific parameters for when to administer 1 tab vs. 2 tabs to the resident. The failure to note the order discrepancies and inappropriate order and clarify with the 2 providers was confirmed with the RN on the morning of 9/7/17.	R128	5.5 c (b) Resident #2 Each resident's medication, treatment and dietary service have been reviewed to assure consistency with the Physicians orders. Psychiatrist and primary care physician clarified Trazadone to be 50mg at bed time. Staff RN will review 4 resident records each month to assure physician orders and medication administration records match. RN Manager will review checklist of records audited by Staff RN monthly.	9/26/17 3/31/18
R134 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation	R134		

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R134	Continued From page 2 implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to complete the admission assessment within 14 days of admission for 1 of 3 residents in the sample. (Resident #1) Findings include: Per review of the admission assessment for Resident #1, the date of admission to the facility was 8/16/16, and the date the Resident Assessment (required by the state) was completed was 9/19/16, a period greater than 2 weeks from admission. The late admission assessment was confirmed during interview with the RN/owner on the morning of 9/7/17.	R134	5.7 Resident #1 An assessment will be completed on each resident within 14 days of admission. A check list will be developed by October 31, 2017 for RN's to complete required paperwork, and reviewed by the licensee at least every quarter.	10/31/17
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to develop a written care plan to address all of the identified needs, including interventions and services necessary to assist the resident in maintaining health and well-being for 1	R145	5.9.c Resident #2 Residents care plans will include each identified need including interventions and services they are receiving to meet the need. The plan of care will describe the care and services necessary to assist the resident to maintain independence and well being. Care plan will be updated and revised as needed. Care plan for weight loss added for Resident #2 on 9/21/17.	9/21/17

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R145	Continued From page 3 of 3 applicable residents in the sample. (Resident #2). Findings include: Per record review, Resident #2 had been residing in the home for approximately 10 months at the time of survey and the resident had sustained a significant weight loss since admission and had been receiving psychosocial and medical services to help treat this need. However, there is no written care plan to address the issues and no written interventions to direct staff in the management of the concerns. The resident was recently diagnosed with gastroparesis and the physician gave a list of recommendations including several small meals daily and these interventions had not been added to the treatment sheet nor a care plan.	R145		
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to assure that a list was maintained for each resident that included the resident's name, medications, date the medication was ordered, and dosage and frequency of administration. for 3 of 3 residents in	R147	5.9.c 4 Resident #1 – 3 Resident's records will be reorganized to include a list with name, medication, date the medication was ordered, dosage or frequency of administration and likely side effects to monitor by Staff RN on a continuing basis starting on 10/1/17. Physician standing orders will be updated with Physician consult by 11/1/17 to eliminate non specific orders and dosage ranges. Three records will be selected for audit quarterly by staff RN.	11/1/17

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R147	<p>Continued From page 4</p> <p>the applicable sample. (Residents # 1 - 3). Findings include:</p> <p>Per review of the facility's Physician Standing Orders (S.O.) that were signed and dated for the three residents in the applicable sample, the orders for acetaminophen stated: acetaminophen 325, 500 mg., 650 mg., or 1000 mg., P/O. P.R., Q 4 HRS PRN elevated temp or discomfort. The orders for acetaminophen did not specify a specific dose and frequency of administration. As stated, the order would allow for a resident to be administered 1000 mg. of acetaminophen Q 4 hours (6000 mg max. per day), which is above the maximum daily dosage per day of 4000 mg. per day. (Nursing drug Handbook 2017). During interview, the RN/owner stated that she writes the orders on the MAR (medication administration record) based what the particular resident needs for managing their pain, using one of the stated doses in the PRN order and adding the frequency. Resident #2 had an order written on the MAR as "Tylenol 500 mg. PO PRN Q 4 HOURS PRN pain". When the original MD order could not be located, the RN stated she had taken the orders from the S.O. signed by the physician upon admission to the facility.</p> <p>Additional S.O. included orders that were not specific and included a range of dosages with no written parameters on when to administer each different dose. (For example, Senokot, 1 - 4 tabs per day PO, and Dimetapp Elixir, 1 - 2 tsp. PO Q 4 HR.)</p> <p>These orders needing clarification and/or parameters were confirmed during interviews with the RN throughout the afternoon of 9/6/17.</p>	R147	<p>5.9.c 4 Resident #1 - 3</p> <p>Resident's records will be reorganized to include a list with name, medication, date the medication was ordered, dosage or frequency of administration and likely side effects to monitor by Staff RN on a continuing basis starting on 10/1/17.</p> <p>Physician standing orders will be updated with Physician consult by 11/1/17 to eliminate non specific orders and dosage ranges. Three records will be selected for audit quarterly by staff RN.</p>		<p>u/1/17</p>

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R179 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.11 Staff Services</p> <p>5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:</p> <ul style="list-style-type: none"> (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that all staff providing care to residents completed at least 12 hours of training each year, including the 7 Vermont required trainings listed in the Residential Care Home (RCH) Licensing Regulations. Findings include:</p>	R179	<p>5.11, 5.11.b The facility will insure that all staff providing direct care to residents will complete at least 12 hours of training each year, including the seven Vermont required trainings listed in the RCH regulations. The licensee met on 9/20/17 with three staff members who were identified as missing required training and confirmed the staff had met the requirement by reading the in service material and signing off on each competency. A new documentation sheet will be developed by November 30, 2017 for each competency so that direct care workers are accurately recorded when they do not attend In Service meetings in person. Office manager will review documentation of in-services quarterly to assess for compliance. Licensee will review reports of compliance provided by Office manager.</p>	<p>9/20/17</p> <p>11/30/17</p> <p>11/30/17</p>

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R179	Continued From page 6 Per review of the annual in-service records for the home's staff, for three of five staff training records (Vermont RCH required) reviewed, one staff was missing 5 trainings and 2 staff were missing 1 training each. During interview on the afternoon of 9/6/17, the owner confirmed the lack of documented trainings for the 3 staff identified.	R179			
R232 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the home failed to assure that menus were planned and written at least one week in advance. Findings include: Per observation of the menu in the kitchen and dining room areas of the home on the first day of survey, 9/6/17, there were no lunch or supper items listed for 9/7/17. During interview with the daily cook on duty on 9/6/17, s/he stated that there are 3 cooks who cover the week's schedule and they each do the menus for the days they each work. S/he was not aware of why the menus were incomplete for 9/7/17 as written. During interview, the manager/owner confirmed on the morning of 9/6/17 that the menu was incomplete.	R232	7.1.a (1)Menus for regular and therapeutic diets will be planned and written at least one week in advance. Following a meeting with facility cooks on 9/19 and 9/20, menus were prepared and posted for each of the next four weeks and posted as required on 9/20/17. Cooks have been assigned to keep menus up to date and initial each week. Office Manager will review monthly for compliance.	9/20/17	
R247 SS=F	VII. NUTRITION AND FOOD SERVICES	R247			

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R247	<p>Continued From page 7</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that all perishable food and drink was held at the proper temperature: at or below 40 degrees Fahrenheit (F) regarding refrigeration temperatures. Findings include:</p> <p>During a tour of the home's kitchen area on 9/6/17, the large reach-in refrigerator's temperature was noted to read 43 degrees F. The Administrator put a new thermometer in the refrigerator at approximately 9:50 AM. The surveyor noted the close proximity of the refrigerator to the double oven range and that the exhaust hood over the oven was not turned on. Staff present said they do not always turn the hood fan on when the oven is on. (The hood fan helps to remove hot air from the area.)</p> <p>The temperature of this unit was rechecked at 11:00 AM and was still 43 degrees F., quickly going up to 46 degrees F. with the door open. While checking items for proper dating and labeling, the surveyor noted a container of left over food was not cold to touch. The item was removed and the contents tested; the thermometer read as 63.5 degrees F, above safe upper limit of 40 degrees F for cold food storage. The cook stated that the entree (lasagna) had been removed from the freezer in the basement</p>	R247	<p>7.2.b All perishable food and drink will be clearly labeled, dated and held at proper temperatures. New thermometer's have been purchased (9/7/17) for each refrigeration unit, and staff has been instructed on how to read temperatures in Fahrenheit for recording. Staff reviewed and signed off on food storage temperatures at or below 40 degrees fahrenheit. Refrigerator temperature adjusted and staff instructed to keep hood fan running when using the stove. Office Manager will continue to monitor recorded temperatures monthly.</p>	<p>9/07/17</p> <p>10/1/17</p>	

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R247	Continued From page 8 the previous night to defrost for the noon meal. During interview, the cook explained that s/he had brought the entree upstairs and set it on the counter "for a while" and then put it in the refrigerator. During interview with the cook and the Administrator (11:15 AM), it was confirmed that the cook, who works 1 day per week, had not received any formal training in safe food handling practices. Refer also to R249.	R247		
R249 SS=D	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the home failed to assure that dietary staff adhered to the home's "FOOD AND KITCHEN POLICY", related to handling of perishable foods that had been defrosted for resident use on the following day. This practice had the potential to affect one resident who had requested the item for lunch on 9/6/17. (Resident #4) Per observation in the kitchen on 9/6/17 at 11 AM, an entree item stored in the refrigerator felt too warm when picked up from the shelf to observe for food dating and labeling. The container was removed and placed on the counter and	R249	7.2.b, 7.2.d, 7.3.b Facility has contracted with "Training to Excel" to certify every cook and three staff food preparation personnel with <u>Serve Safe</u> certification in either Manager or Food Handling areas. The course will be held at the facility on October 23 and 24, 2017. Each cook and food handler has reviewed the facility's FOOD AND KITCHEN POLICY, signed and dated same, and been reminded of possible disciplinary action should the policy fail to be followed. In addition, all unpainted surfaces in the food preparation area will be painted and/or sealed by November 30, 2017. Individual staff certification certificates will be filed with personnel records.	10/20/17 11/30/17

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R249	Continued From page 9 immediately a thermometer probe was inserted to take the contents' temperature. The container held left over lasagna that had been defrosted in the down stairs walk-in cooler the previous night for lunch for 1 resident who had requested the entree. The temperature of the lasagna was 63.5 degrees F. when tested at 11:05 AM. During interview, the cook stated that s/he had brought the lasagna upstairs and left it on the counter for "a while" before placing it in the refrigerator. The cook confirmed that s/he had not received any formal training in safe food handling procedures but did acknowledge that cold prepared foods should be stored in the refrigerator except when heating them just before meal service. Refer also to R247.	R249		
R252 SS=D	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to assure that areas of the home used to store food, drink, equipment or utensils were constructed to be easily cleaned. Findings include: Per observations in the kitchen on 9/6/17, the shelves in cabinets used for food/drink and	R252	7.2.b, 7.2.d, 7.3.b Facility has contracted with "Training to Excel" to certify every cook and three staff food preparation personnel with <u>Serve Safe</u> certification in either Manager or Food Handling areas. The course will be held at the facility on October 23 and 24, 2017. Each cook and food handler has reviewed the facility's FOOD AND KITCHEN POLICY, signed and dated same, and been reminded of possible disciplinary action should the policy fail to be followed. In addition, all unpainted surfaces in the food preparation area will be painted and/or sealed by November 30, 2017. Individual staff certification certificates will be filed with personnel records.	10/31/17 11/30/17

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R252	Continued From page 10 utensil storage were constructed of bare, unsealed wood and were not easily cleanable in multiple areas of the kitchen. The shelving was observed with the Administrator present during the late morning hours.	R252		